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Health reform in Nigeria: the politics of primary health care and universal health coverage

Kevin Croke[1,*] **and Osondu Ogbuoji**[2]

[1]Department of Global Health and Population, Harvard T.H. Chan School of Public Health, 677 Huntington Ave, Boston, MA 02115, USA
[2]Center for Policy Impact in Global Health, Duke Global Health Institute, Duke University, 310 Trent Drive, Durham, NC 27710, USA

*Corresponding author. Department of Global Health and Population, Harvard T.H. Chan School of Public Health, 677 Huntington Ave, Boston, MA 02115, USA. E-mail: kcroke@hsph.harvard.edu

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Abstract

Over the past decade, Nigeria has seen major attempts to strengthen primary health care, through the Saving One Million Lives (SOML) initiative, and to move towards universal health care, through the National Health Act. Both initiatives were successfully adopted, but faced political and institutional challenges in implementation and sustainability. We analyse these programmes from a political economy perspective, examining barriers to and facilitators of adoption and implementation throughout the policy cycle, and drawing on political settlement analysis (PSA) to identify structural challenges which both programmes faced. The SOML began in 2012 and was expanded in 2015. However, the programme's champion left government in 2013, a key funding source was eliminated in 2015, and the programme did not continue after external funding elapsed in 2021. The National Health Act passed in 2014 after over a decade of advocacy by proponents. However, the Act's governance reforms led to conflict between health sector agencies, about both reform content and process. Nine years after the Act's passage, disbursements have been sporadic, and implementation remains incomplete. Both programmes show the promise of major health reforms in Nigeria, but also the political and institutional challenges they face. In both cases, health leaders crafted evidence-based policies and managed stakeholders to achieve policy adoption. Yet political and institutional challenges hindered implementation. Institutionally, horizontal and vertical fragmentation of authority within the sector impeded coordination. Politically, electoral cycles led to frequent turnover of sectoral leadership, while senior politicians did not intervene to support fundamental institutional reforms. Using PSA, we identify these as features of a 'competitive clientelist' political settlement, in which attempts to shift from clientelist to programmatic policies generate powerful opposition. Nonetheless, we highlight that some policymakers sought to use health reforms to change institutions at the margin, suggesting future avenues for governance-oriented health reforms.

Keywords: Politics of health reform, political economy, primary health care, universal health coverage, Nigeria

Key messages

- Nigeria has attempted major health reforms over the past 15 years, including programs to strengthen primary health care and to improve health financing and governance.
- These reforms were successfully adopted. However, in both cases, they faced challenges in implementation. These challenges were rooted in political and institutional features of Nigeria's context.
- Horizontal and vertical fragmentation of authority within the health sector made coordinated action difficult and costly.
- Health reformers developed strategies to address accountability gaps in the health sector. However, these efforts had limited success because senior politicians did not spend political capital to ensure fundamental institutional reforms.

Introduction

Nigeria has the largest number of under-5 and maternal deaths in the world, and is not currently on track to achieve key health Sustainable Development Goals (Ogbuoji and Yamey, 2019). Health outcomes are poor not just in absolute terms, but also when compared to other countries with similar income per capita (Abubakar *et al.*, 2022). Nigeria is the world's 13th largest oil producer, but its spending on health as a per cent of GDP is second lowest in the world (Tulloch *et al.*, 2017).

In response to these challenges, Nigerian policymakers have put forward important health initiatives over the past decade, including the National Health Act, large-scale primary health care (PHC) programmes such as the Saving One Million Lives (SOML) programme, the National Health Insurance Authority Bill of 2022, and other major reforms. In this paper, we analyse two initiatives. Focusing on PHC, we study the adoption and implementation of the SOML initiative, starting in 2012. For universal health coverage (UHC), we analyse the 2014 passage and subsequent implementation of the National Health Act, especially the Basic Health Care Provision Fund(BHCPF) component.

We apply a political economy lens to these initiatives, drawing on several theoretical traditions. Our primary theoretical lens is that of the politics of policy reform (Grindle and

Thomas, 1991; Kaufman and Nelson, 2004; Roberts *et al.*, 2004). These models seek to explain the success or failure of policy reforms in low and middle income countries through a two-part framework, combining analysis of the characteristics of reform-oriented policy elites (their ideas, training, professional backgrounds, ideological commitments, and personal attributes) with the political context, most notably the relative power of actors and groups in favour and opposed to the reform. This approach recognizes that health policy elites have agency in setting the reform agenda, while acknowledging that they are constrained by the political context in which they operate. We follow this framework's use of the policy cycle model (agenda setting, adoption and implementation) to structure our case narratives. Second, in order to identify factors that explain the relative strength of different interests, we draw on the concept of the 'political settlement' and its relationship to service delivery (Kelsall *et al.*, 2016; Bukenya and Golooba-Mutebi, 2020). The political settlement is defined by Khan (1995) as 'the "social order" based on political compromises between powerful groups in society that sets the context for institutional and other policies'. This underlying political settlement forms the basis for the relative power of different interests in the health sector. We seek to classify Nigeria's political settlement according to the typology presented by Kelsall *et al.* (2016), and use this to inform our analysis. In our view, the outcomes of specific health policy debates are downstream of the fundamental political equilibrium in society. Therefore, combining a focus on the proximate determinants of policy adoption with analysis of the political settlement can enable a fuller picture of both the short- and long-run dynamics of health policy change.

Materials and methods

To inform this analysis, we examined multiple sources, including first-person accounts of Nigerian leaders over this period (Lambo, 2014; Jonathan, 2018; Okonjo-Iweala, 2018), case studies of health programmes (Tulloch *et al.*, 2017; Alawode *et al.*, 2022), national health policy documents and reports, and 23 interviews with stakeholders from Nigeria's health sector, including senior policymakers (Table 1). Additionally, we conducted a review of the recent political science literature on Nigerian politics (e.g. Agbaje *et al.*, 2018; Levan, 2019; Usman, 2020). Respondents were initially identified based on review of programme and organizational documents; further respondents were added via snowball sampling. Interviews were conducted in person and via Zoom between 2020 and 2023, and were conducted until saturation was achieved. Interview transcripts and notes were reviewed and themes were developed based on this review. Interview material was reorganized based on these themes and triangulated against published documents and data sources. A draft version of the manuscript was also shared with several individuals with personal experience of the events in question at senior levels in government or in non-governmental organizations.

By examining two distinct policy reforms in Nigeria, we use a within-case comparative design. Within-case designs have advantages relative to single case studies in that the researcher can learn from cross-case variation in explanatory variables and outcomes, while retaining comparability between cases due to similar background conditions (Goertz and Mahoney, 2012).

Table 1. List of interviewees

Respondent	Position
Interview 1	SOML implementing agency (NACA)
Interview 2	Office of the President (Nigeria)
Interview 3	SOML staff, Ministry of Health
Interview 4	BHCPF Secretariat employee
Interview 5	SOML employee
Interview 6	Research staff involved in SOML (SURE—P MCH) evaluation
Interview 7	Member of SOML (SURE—P MCH) Project Implementation Unit
Interview 8	Consultant to BHCPF and state health insurance agencies
Interview 9	SURE P MCH employee
Interview 10	Member of SOML PDU
Interview 11	World Bank staff, Nigeria country office
Interview 12	Ministerial level official
Interview 13	World Bank staff
Interview 14	World Bank staff, Nigeria country office
Interview 15	Senior Ministry of Health employee
Interview 16	Ministerial level official
Interview 17	Senior Ministry of Health employee (second interview)
Interview 18	Donor official
Interview 19	Health sector NGO official
Interview 20	Donor official
Interview 21	Donor official
Interview 22	Health sector NGO official
Interview 23	Ministerial level official (second interview)

Results

Background: health policy dynamics in Nigeria

Health services in Nigeria's post-independence First Republic were largely focused on curative hospital care. A focus on PHC first emerged in the late 1970s, when the Basic Health Services Scheme (BHSS) used rapidly increasing oil export revenue to build basic health units (BHUs) in every local government area (LGA). The BHSS faltered due to lack of stable financing (Odutolu *et al.*, 2016). However, when BHSS head Professor Olikoye Ransome-Kuti became Minister of Health in the mid-1980s, he prioritized PHC: he founded the Primary Health Care Directorate of the MOH, piloted PHC programmes in 52 LGAs, and created the National Primary Health Care Development Agency (NPHCDA) (Ikweazu, 2015). Yet progress halted under the regime of General Sani Abacha, whose personalization of power and diversion of public resources damaged social services, including health and education (Okonjo-Iweala, 2012).

After the unexpected death of General Abacha in 1998, democracy returned in 1999 with the election of President Olusegun Obasanjo (1999–2007). While health was not Obasanjo's main policy priority, initial steps towards health reform began during this period. However, President Obasanjo was succeeded by President Yar Adua, who quickly fell ill, pausing any reform currents. After President Yar Adua's death in 2010, previously little-known Vice President Goodluck Jonathan assumed the presidency. His presidency saw the initiation of the SOML programme (2012) as well as the passage of the National Health Act (2014). We discuss these two programmes below.

Saving One Million Lives

Agenda setting

The SOML programme was designed by President Jonathan's Minister of State for Health Muhammad Pate, building on

several programmes developed since his appointment as head of the NPHCDA in 2008. Dr Pate had been recruited back to Nigeria from the World Bank to revitalize Nigeria's then-flagging polio eradication drive (Interview 12). While at NPHCDA, he developed the Midwives Service Scheme (MSS). A precursor to SOML, the MSS posted 2500 midwives to underserved primary health facilities across all 36 states of Nigeria. After his appointment as Minister of State for Health, Dr Pate designed the SOML programme, drawing on elements of MSS, as well as strategies from polio eradication efforts and other previous experiences. SOML targeted new resources at the drivers of under-5 mortality in six areas: maternal and child health, polio and routine vaccinations, malaria control, nutrition, access to essential medicines, and prevention of mother-to-child transmission of HIV (PMTCT). The idea of saving 'one million lives' was influenced by Minister Pate's memory of the Institute for Healthcare Improvement's '100000 lives' quality improvement campaign in the US (Interviews 3, 12); in his words, he 'just added a zero' to this goal. Programme staff used the Lives Saved (LiST) modelling tool to estimate that scaled-up coverage of interventions in the six SOML programme areas could prevent a million deaths cumulatively over three years (Interview 10), giving the programme its memorable name. While building on previous Nigerian policies such as the MSS, SOML also aligned with then-current global health policy ideas (targeted, cost-effective interventions, conditional cash transfers, results-based financing), while also linking to both global and political timelines: the initial SOML 3-year period coincided with the 2015 end date of the Millennium Development Goals (MDGs), while also marking the end of President Jonathan's first term.

Policy adoption

The most important element of SOML, the Subsidy Reinvestment and Empowerment Programme: Maternal and Child Health Initiative (SURE-P MCH), was also the most politically complex. Facing a deteriorating fiscal position after his election in 2011, President Jonathan reduced Nigeria's consumer fuel subsidies. (Although Nigeria is a major crude oil exporter, it imports refined petroleum and highly subsidizes it.) The subsidies were expensive and highly regressive, but removing them was unpopular and led to national protests dubbed 'Occupy Nigeria'. Minister of State, Pate, unusually for a minister in the health sector, was a member of the President's Economic Management Team (EMT). This led to Minister of Finance Ngozi Okonjo-Iweala asking Pate to coordinate the development of a multi-sectoral safety net proposal for the oil subsidy savings. Drawing on his World Bank experience and observation of social protection programmes from Mexico, Indonesia and Brazil, Pate contributed to the development of the multisectoral SURE-P. These international experiences both suggested that the funds available from subsidy removal could be devoted to social programmes, and influenced SURE-P design, which was not just focused on supply side inputs to health facilities (as the previous MSS had been) but now also included a demand-side conditional cash transfer for pregnant women (Interview 12). SOML targets were included in the EMT's formal goals, and later when fuel subsidies were partially reinstated and SURE-P funding was reduced, the MCH component was retained, thanks to support from Okonjo-Iweala, other EMT members, and President Jonathan (Interview 3).

The SOML team also cultivated support from President Jonathan directly. Unknown to the SOML team, President Jonathan had deep personal reasons to favour the programme, which only became apparent at the SOML launch event when the President deviated from his prepared text: 'The president went off script and began to tell a narrative about how he had siblings who died in infancy… he actually remembered their faces… he spoke from the heart' (Interview 3).

By leveraging the policy window provided by fuel subsidy removal, crafting a supportive coalition across ministries, and making personal appeals to the president, SOML advocates achieved policy adoption. However, the initiative faced challenges of implementation, including full programme financing. The full SOML programme had an estimated cost of $5.8 billion over 3 years; more than three times the 2013 federal MOH budget. Yet while SURE-P MCH had dedicated budget lines and regular funding, the other programmes relied on ad-hoc donor contributions (Interview 10). The SOML team received lukewarm support from many bilateral donors, but enthusiasm from the Children's Investment Fund Foundation (CIFF), the Clinton Health Access Initiative, the Bill and Melinda Gates Foundation (BMGF), and the World Bank (Interview 3). The World Bank was initially approached; their project development timelines were too slow to fund the first years of SOML, but they were open to developing a larger project (Interview 12). The strategy for longer term SOML financing therefore shifted to focus on developing a World Bank loan proposal. This loan, initiated in 2015, funded a substantial portion of SOML activities, although it coincided with the discontinuation of the SURE-P MCH financing stream, as fuel subsidies were re-instituted and Nigeria's overall fiscal position deteriorated.

Policy implementation

'The governors are kings. You are actually running 37 different health systems. So what do you have? Soft power'. (Interview 3)

With the adoption of SOML secured and partial financing in place, the next challenge was implementation. In this context, the challenge for the SOML team was to mobilize other public institutions—state and local governments, NPHCDA, NHIS, and others—to implement SOML effectively, since the Federal Ministry of Health (FMOH) was only directly in charge of tertiary health services.

At FMOH, an SOML Program Delivery Unit was funded by the Gates Foundation. This unit's staff, recruited from outside civil service, included young internationally trained Nigerians—like 'an NGO within the Ministry of Health' (Interview 6). The unit developed strategy, coordinated monitoring and evaluation, and liaised with states responsible for implementing SOML. Similarly, SURE-P MCH was coordinated by a programme implementation unit within NPHCDA (Interview 7, Uzochukwu *et al.*, 2020). Two elements enabled implementation of SURE-P. First, SURE-P MCH's consistent, predictable funding enabled substantial outreach to state and local officials, bringing them to Abuja for workshops to explain the programme's goals. Project Implementation Unit staff believed this was necessary, given Nigeria's federalized administrative structure (Interviews 5, 7, 9). SURE-P MCH also avoided the bottlenecked funding structure of PHC programming in Nigeria. SURE-P funds flowed from the oil subsidy fund directly to delivery units; activities only required

one signoff from NPHCDA (Interview 9). By contrast, normal budget allocations for PHC went first to states and then to LGAs. Funding was unpredictable with leakage and frequent refusals by state officials to release LGA PHC funding (Interviews 1, 7, 9).

Second, lacking direct line authority over states or other health agencies, the SOML group used 'soft power' to mobilize implementation. Building on experiences with Nigeria's polio eradication drive where similar strategies were used, state-level SOML progress was presented quarterly, via scorecards, in public governors' meetings and in newspapers. They also leveraged the existence of a health official within the Governor's Forum to press their agenda (Interview 3). SOML leaders also seeded story ideas in the media to pressure governors to address problems with implementation. While state governors had authority over the health sector, they were rarely held accountable for results. The SOML team sought to generate accountability through the use of data and by leveraging existing institutional fora.

Sustainability

'Normally when a new government comes on board, the thinking is to dissolve anything which is not permanent'. (Interview 7)

'[SOML] was meant to come in like any catalyst and shake things up… Like any catalyst, it works for a while and moves on'. (Interview 3)

A challenge for SOML's sustainability emerged when the programme's designer, Minister of State Pate, left FMOH in 2013. Implementation lost some momentum and the ministry's commitment to the programme was weakened (Interviews 4, 6). The PDU left the FMOH, becoming part of a new NGO, the Health Strategy and Development Foundation. In 2015, two events marked another transition for the programme. When President Jonathan lost re-election to Muhammadu Buhari, the programme lost its original sponsor, as well as many supporters within government. The SURE-P MCH element was abruptly discontinued due to the perception that 'this was Goodluck Jonathan's project' (Interview 7): 'SOML became an orphan. No one was owning it. There was no appropriation for it'. (Interview 11).

Second, in 2015, SOML was folded into a World Bank project called the SOML-Program for Results (PforR), securing additional funding but also shifting the programme design in important ways. SOML architects saw this as a way to institutionalize the programme, and to secure future funding. Final loan documents were signed on the last day of outgoing Minister of Finance Okonjo-Iweala's term, but the loan was almost not finalized. The new administration viewed it as a holdover from the last administration, and felt that members of the former SOML PDU, outside government since 2013, had overly influenced the project's design (Interview 6).

The SOML PforR project was a $500 m World Bank loan; to be matched by $552 m from the federal government over 5 years. The project used the World Bank's then-new 'Payment for Results' (PforR) model, such that successive disbursements of the loan would be made based on Nigeria's achievement of five indicators, such as number of children immunized or number of births in health facilities, increased transparency in budgeting, and establishment of an innovation fund (World Bank, 2015). All states were to receive $1–2 million in start-up funds. After that, each state was to be eligible for an additional $205 000 per percentage point gain beyond six percentage points. The best-performing states per region were eligible for further bonuses of $500 000–$1 million.

Implementation of the PforR scheme faced challenges. First, the programme's placement in the FMOH was seen as a mistake by some participants, since the FMOH's mandate is largely tertiary rather than primary care. But given that NPHCDA had just been implicated in scandals related to funding from the Global Fund to Fight AIDS, TB, and Malaria and the Global Alliance for Vaccines and Immunization, it was seen as impossible to give them the project (Interview 11). Others saw it as the World Bank shifting towards FMOH because they perceived that NPHCDA leaders were less politically favoured, in part because former NPHCDA head Dr Pate had recently left government (Interview 12). Second, the results-based financing element was controversial. Payments were supposed to be higher for poorer performing states, largely in Nigeria's north. Southern states strongly objected. A compromise resulted in each state receiving $1.5 million, instead of $1 million for stronger performers and $2 million for poorer performers (Interviews 3, 14, 16). Then, at the end of year one, when few states had improved enough to merit increased funding, state leaders protested, and the FMOH agreed to advance funding. Finally, the judgements of the independent verification agent were contentious and, in several cases, were seen as incorrect by the World Bank itself (Interviews 6, 11); several audits were contested, and several state-level irregularities were documented (Bridges and Woolcock, 2023). Results, as measured by the SOML monitoring survey, were also contested. In the 2019 survey, payment-linked indicators were significantly better than expected (Interviews 14, 16). The World Bank challenged the survey methodology (World Bank, 2021), highlighting issues with fieldwork implementation and construction of survey weights. The MOH agreed and asked for a World Bank technical review, which had not been published at the time of writing (Interview 16). The loan was rated 'moderately satisfactory' by the World Bank evaluation unit, disbursing $388 m out of planned $500 m. Little of the planned $552 m counterpart funding was produced, due in part to oil price declines which created fiscal challenges. Despite positive, although contested, results from monitoring surveys, ultimately the World Bank did not continue the programme beyond the loan's end date; originally 2019 but extended to 2021 after several project restructurings (Interviews 3, 14). In this sense, the SOML programme essentially ended in 2021.

The National Health Act

While SOML sought to reduce preventable mortality by targeting key interventions, the National Health Act addressed health financing and health governance gaps: low health spending per capita, high out of pocket expenditures and limited funding at facility level, as well as institutional fragmentation and weak accountability in health institutions (Adeyi, 2022).

While the Act had numerous provisions, the most substantial was the creation of a new funding and intergovernmental fiscal transfer instrument known as the BHCPF. This reform was designed to both improve the fiscal transfer and budget execution systems to give facilities meaningful operational

resources, while also spurring the creation of insurance mechanisms to pool funding and reduce out-of-pocket spending. Previous health financing reforms, such as the Formal Sector Social Health Insurance Program, had fallen short on these goals. This programme was particularly promising since it addressed major, persistent shortfalls of Nigerian's health system, including accountability and oversight, as well as delivery of basic operational funds to health facilities. It also clarified the funding and payment mechanisms for channelling funds to states from the federal government.

Agenda setting

The long path to the NHA started shortly after Nigeria's democratic transition in 1999. In 2000, the WHO had ranked global health systems, rating Nigeria among the poorest performers in the world (Interview 19). One response to this came via the United Kingdom Department for International Development (DFID)-funded 'Change Agents' programme (2001–2004), which supported a small cohort of health professionals to critically analyse Nigeria's health system (Interviews 19, 20). The programme had been designed in consultation with a WHO Nigerian health economist, Prof. Eyitayo Lambo, who was then tapped to head the group. These Change Agents, selected from disparate organizations and fields, networked and did study tours to places like Ghana and South Africa; on their return, many became influential advocates for health reform, founding the Health Reform Foundation of Nigeria (HERFON). A group of them also wrote a letter to all political parties before the 2003 elections outlining a proposed reform agenda, which laid out reform principles that remained influential. Prof. Lambo became the first head of HERFON, and in 2003 was tapped as Minister of Health by President Obasanjo (Lambo, 2014).

Policy adoption

With a leading health reformer as minister, major health reform along the lines supported by HERFON might have seemed imminent. Indeed, in 2007, a National Health Act passed the Federal Executive Council and the Senate. Yet, the bill did not pass the House before Obasanjo's term expired, so the law was not adopted (Tulloch *et al.*, 2017). A similar bill passed both legislative branches in 2011, but this time was not signed by President Jonathan.

Several factors explain these failures. First, the bill had strong support from civil society organizations, but lacked champions inside government. Without high-level champions, there were limits to the ability of donor-funded civil society groups such as HERFON to drive major reforms (Interview 20). Second, the 2011 bill was actually opposed by Minister of Finance Okonjo-Iweala, who was wary of the budgetary implications—this version of the bill required 2% of the Consolidated Revenue Fund (CRF) to be earmarked for health—and feared a repeat of the Universal Basic Education Commission experience, where earmarked education funding often went undisbursed (Interviews 19, 20, 22). Religious groups opposed provisions regarding organ transplants, while several health professional associations opposed reservation of hospital management positions for doctors. The bill had lukewarm support from the Ministry of Health, which received minimal resources in this draft. States also objected to de facto restrictions on their budget autonomy (Interviews 19, 20, 22).

The NHA was finally passed in 2014, at the end of President Jonathan's term. The Act had two central provisions related to health financing and governance. First, it mandated that at least 1% of Nigeria's CRF be allocated to the BHCPF (in 2019, 1% of the CRF was $130–140 million). Second, this amount must be divided between health insurance (50%), direct support to facilities (45%) and emergency care (5%) (Alawode *et al.*, 2022). The NHA was also seen as a vehicle to improve governance, notably the fragmentation of Nigeria's health institutions and limited accountability: Per one senior official, fragmentation between federal and state ministries meant that Nigeria's health sector essentially had 'no formal accountability system' (Interview 13). By pairing a new, integrated funding stream with strengthened oversight and audit functions, the Act sought to direct badly needed resources to the service delivery front line while making the governance improvements to ensure that the funds would be disbursed and used appropriately.

Several political strategies were used to win passage this second time. First, the Act's promoters made significant changes, reducing funding from 2% to 1% of the CRF, and added FMOH funding. The allocation was no longer from the total revenue fund (which includes earmarked state resources) but only from federal funding; this reduced state opposition. Second, in contrast to 2011, HERFON conducted strategic outreach to opponents. They addressed concerns from religious organizations about organ donation and other medical procedures, and from health worker associations. They also directly lobbied power brokers, including the traditional leader of President Jonathan's ethnic community, and the leader of his political party. To address the Ministry of Finance's concerns, HERFON modelled the economic and health benefits of the law (Interviews 16, 19). Finally, the upcoming election raised the stakes for President Jonathan and may have convinced him to support the NHA.

Implementation and sustainability

Implementation of the NHA would prove no less contentious than passage of the legislation. Shortly after signing the law, President Jonathan lost re-election to President Buhari. In 2015, President Buhari appointed Professor Isaac Adewole as the Minister of Health. Adewole was an academic clinician and former Vice Chancellor of the University of Ibadan. Through his period in office, Ministry of Health leaders worked to implement the key elements of the NHA, by seeking funding for the BHCPF and by developing standardized procedures for its operations.

Before Professor Adewole took office, a technical working group (TWG) was created to develop an operations manual for the BHCPF (Tulloch *et al.*, 2017). This group, which comprised five technical subcommittees, was chaired by FMOH with representation from NPHCDA, NHIS and other stakeholders (Interview 15). Prof. Adewole, conscious of the short tenure of previous Ministers, grew frustrated when his requests for committee reports did not yield results. The minister's frustration led to the working group being either disbanded (Interviews 16, 18) or sidelined, and the FMOH staff began drafting a separate operations manual, with World Bank technical assistance and influence. The original TWG eventually produced its own parallel guidelines. These competing versions were eventually harmonized into a single set of

guidelines in late 2016. However, tensions persisted between the two groups.

The FMOH sought four key design elements: there should be one common 'basket' of funds; transfers should be made electronically; funds must go directly to facilities; and there should be strong oversight of implementation by a ministerial steering committee, chaired by the Minister of Health (Interviews 15, 17). The Operations Manual that they developed reflected these priorities.

However, the disputed guideline development process reflected several fundamental disagreements. These included disagreements over which institutions should control this new channel of money, over which accountability structures should exist, over the role of donors in the process, and over the manual development process itself. NPHCDA opposed direct disbursement of funding to PHCs (Interviews 14, 18), which was a high priority for the Minister. This was explicitly modelled on the direct disbursement element of the World Bank's Nigeria State Health Insurance Project (NSHIP). Adewole's support for direct disbursement was strengthened when he made incognito visits to NSHIP facilities in Nasarawa state and saw the benefits in person (Interviews 11, 14, 15, 16). This personal experience was supported by evidence from a concurrent impact evaluation (Khanna *et al.*, 2021).

A second set of disagreements was around the Ministerial team's insistence on new accountability mechanisms (a high-level BHCPF oversight committee) and new structures whereby donor funds could be pooled with government revenue (which entailed allowing donors to audit the account). The oversight committee, chaired by the Minister of Health and including the Ministries of Finance, Education and Budget, NPHCDA, NHIS, and the Presidency, was to monitor disbursements directly, with specified time limits for disbursement to limit delays (Interviews 15, 18). Funding would be sent quarterly from the Central Bank of Nigeria to health facility bank accounts. The Minister's team saw this transparency and auditability as key governance reforms; central to gaining support from donors and enabling the merging of donor and government funds in the BHCPF (Interviews 15, 16). Previously, delayed disbursements and lack of transparency and accountability in intra-fiscal transfers had been major issues (Interview 18). Moreover, the minister's team stressed that under realistic assumptions about the CRF budget, the BHCPF allocation would amount to less than $1 per capita. No health system transformation would be possible without a larger resource envelope, enabled by the basket mechanism.

By contrast, NPHCDA and NHIS saw their existing accountability mechanisms as adequate. Some legislators saw this auditability—and the presence of donors in the Secretariat—as an infringement on sovereignty. More generally, they opposed the role of the BHCPF Secretariat, which was donor-funded and located in the Minister's office (Alawode *et al.*, 2022). The NPHCDA saw itself as the responsible agency for the BHCPF (per the text of the law); furthermore, as autonomous agencies, the NHIS and NPHCDA did not feel that their work plans and budgets should be subject to approval from a group led by an FMOH department head (Interviews 17, 18). Believing the Secretariat lead and Ministry department chair to be below them bureaucratically, they started boycotting Secretariat meetings (Interview 18). They deeply resented the role of donors (Interviews 20, 22) and the Ministry in this process.

Overlying these policy design disagreements was resentment about the process by which the BHCPF Operations Manual had been developed. Long-time health reformers felt that they had been bulldozed by the Minister when he dissolved the original TWG, and felt that the Ministry pushed its Operations Manual through the National Council on Health improperly (Interviews 19, 20). Critics argued that the Minister's rush resulted from time spent on an ill-fated attempt to refurbish 10 000 PHC facilities—an ambitious plan, supported heavily by the local UNICEF office, which 'cost two years' (Interview 20) of lost time. FMOH defenders argued that the original TWG did not produce a functional manual, and argued that PHC renovation plans did not distract from NHA implementation.

Responding to the Ministry of Finance's request for proof of concept before appropriation of funds for national implementation, the Ministry of Health proposed a BHCPF pilot in Abia, Osun and Niger states, funded by the Global Financing Facility (GFF) ($20 m) and Gates Foundation ($2 m). This pilot was based on the operations manual developed by the FMOH team, incorporating compromises with NHIS and NPHCDA but retaining the core governance reforms of the original draft. The pilot, launched by President Buhari in January 2019, was seen by the Ministry team as a way to lock in commitment to their preferred manual (Interview 15).

Similar contestation surrounded BHCPF funding. Despite the NHA's passage, the 2017 budget did not include any BHCPF allocation. The Minister of Finance did not believe health should receive a percentage of the CRF (despite what the law stipulated); rather, FMOH should request a specific funding amount (Interview 16). The allocation was again not in the first draft of the 2018 budget. A pressure campaign led by the FMOH was mobilized, with interventions from WHO Director General, senior World Bank health officials and local allies including Kaduna Governor Nasir El-Rufai and the chair of the Senate Health Committee, and the Senate President, who eventually forced the inclusion of funds in the revised 2018 budget (Interview 16). More important, it was shifted from a service-wide vote (whereby funds expire if unused) to a statutory allocation in 2019 (in which unused funds are rolled over).

The three-state pilot was designed to move BHCPF activities forward in advance of legislative funding allocation, and provide proof of concept for sceptics in the Ministries of Finance and Budget. The pilot was overtaken by events when the legislature approved national funding in 2018. However, these debates took another turn after Nigeria's February 2019 presidential election. President Buhari won re-election, but Minister of Health Adewole was replaced by then-Minister of State for Health, Dr Osagie Ehanire. Several supportive state Commissioners of Health left office, while several key external partners also left Nigeria. In addition, the Senate President and the chair of the Senate health committee, key supporters of the NHA, left the senate (Interviews 15, 16). New senators supported the opponents of the FMOH operations manual (Interviews 17, 19), including the new Senate chair of the health committee, who was one of the original 'Change Agents' from the early 2000s.

This set in motion a series of events which changed the BHCPF substantially. A committee was created to review BHCPF procedures, and disbursements were paused while the review was ongoing. The review resulted in changes to the operations manual, governance, the funding formula, and the minimum package (Interview 4). NHIS pushed for an expanded benefit package, comparable to the civil service package (from N4000 per person to N12 000), reducing the number of people who could be covered with the given budget envelope. Debates restarted about how NHIS would pay providers, with a proposed shift from fee-for-service to capitation. Earmarking of BHCPF transfers for specific line items was introduced; previously funds had been unrestricted (Interview 15). The steering (now oversight) committee was weakened, reduced to passively collating reports from agencies. The Secretariat was moved out of the Minister's office; seconded staff from the Ministry of Finance, who knew how to facilitate disbursements, were sent back (Interview 17). Funding for public health emergencies (originally in the bill, then removed) was re-installed (Alawode *et al.*, 2022). Essentially, the transparency, auditability and 'basket' elements of the BHCPF were eliminated (Interviews 15, 16). What remained was the electronic transfer of funds and direct funding to facilities.

Some saw this push-and-pull as part of the normal policy process—even as consensus building (Interview 13)—while others saw a 'policy somersault' (Interview 8), a dramatic change that eliminated core elements of the reform. BHCPF processes largely stalled while these changes were debated: while two disbursements were made to facilities over BHCPF's first year, only two were made in the subsequent three years, leading to repeated Governor's Forum complaints about the slow pace of disbursements (Interviews 17, 19). Donors also withdrew commitments: the government refunded $10 m to the World Bank, DFID/UKAid did not fulfil a £60 m commitment (Interviews 16, 17), and BMGF shifted a commitment of $80 m over 5 years into a new modality linked to achievement of vaccination allocation targets (Interviews 18, 21).

Discussion

'All of these things would have been solved easily if we had a head of government who was keenly interested in the health sector and had specific goals he wanted to achieve… We didn't have that'. (Interview 20)

SOML and the NHA both show that major health programmes and reforms can be designed, proposed and adopted in Nigeria, at the initiative of reformist bureaucrats and civil society actors with ideas rooted in their technocratic expertise. SOML was a largely minister-driven reform, while the NHA emerged from civil society and professional movement activism, catalysed by DFID support. However, after achieving adoption, both programmes faced challenges which slowed implementation and challenged their sustainability. These challenges were rooted in institutional gaps, which, in turn, reflected Nigeria's political settlement.

Initially, both policies faced opposition from interests which stood to lose resources or power. SOML's approach, especially SURE-P's financing via fuel subsidy removal, generated opposition, eventually leading to the reimposition of fuel subsidies, removing a source of recurrent funding. The NHA faced opposition outside and within government over the decade prior to adoption. Reformers modified the bill itself and their strategies, and it won passage in 2014. After passage, the core issue was competition among agencies for control; the proposed changes would have expanded FMOH's power over other health agencies. Disputes about control were hard to separate from disagreement about the process by which procedures had been developed.

In both cases, policy adoption was achieved, but opposition continued throughout implementation. For SOML, this resulted in programme discontinuation when donor financing elapsed in 2021. For NHA, it meant that the implementation was subject to debate, delay, and revision. Progress had occurred: by 2023 over 7000 facilities had received BHCPF disbursements. But these accomplishments were modest compared to the size of the challenges.

Beyond policy adoption, the implementation and sustainability of both programmes were constrained by the political and institutional context. Both programmes struggled with the inability of Nigeria's federal ministries to compel implementation at state and local level, and the limited formal powers of coordinating bodies such as the National Council of Health and the Governor's Forum. Nigeria's constitution does not give the FMOH control over state MOHs or LGAs, limiting top down accountability for health service delivery.

Adapting to this fragmentation, SOML first used 'soft power' and then financial incentives to motivate state-level action. The NHA team created a BHCPF Secretariat and oversight committee, streamlining processes and improving oversight to limit the ability of state governments to capture resources meant for front line service delivery. For the health insurance component of the Act, states had to create insurance schemes and enrol patients in order to receive funding.

Sustainability for both programmes was challenged by election-related turnover: SOML lost momentum when Minister Pate left government, and SURE-P was discontinued when President Jonathan lost re-election. BHCPF stalled when Minister Adewole was replaced after the 2019 election. Programmes that rely on individual bureaucratic agency are limited by the longevity of such bureaucrats. SOML implementers, perhaps paradoxically, sought to ensure sustainable financing by embedding the programme within a World Bank loan, yet Bank funding for SOML was not renewed after 2021. Recognizing these challenges, the SOML team saw the programme as 'buying time' until the NHA's governance reforms could take root, and introducing ideas which could inform future reforms.

Political economy approaches that focus on the policy cycle and the interest group politics of policy adoption are a form of applied political economy analysis in global health. Such approaches do shed light on how SOML and the NHA reforms were adopted in Nigeria. However, they offer less insight into the challenges of implementation and sustainability over time. Implementation and sustainability were both impeded by the extreme fragmentation of Nigeria's governance, both horizontally (within the health sector) and vertically (between federal, state, and local government authorities), and the lack of accountability embedded in this fragmentation. To gain insights into the deeper roots of these challenges, we turn again to the political settlement framework.

The Political Settlements dataset codes Nigeria as a 'competitive clientelist' settlement for all years during the period in which SOML and NHA were implemented (Schulz and Kelsall, 2021). Competitive clientelist settlements are not autocratic; rather, they are characterized by elite rotation in power (often on regional basis) combined with weak institutions for horizontal and vertical accountability. Political order is based on a distribution of rents among elites. Political competition and elite circulation via elections further raise pressure to use rents for clientelism rather than public service delivery or longer-term institution building. This matches descriptions of Nigerian politics in the political science literature (Lewis, 2007; Agbaje *et al.*, 2018; Levan, 2019; Usman, 2020), and is consistent with the patterns identified by the health sector respondents interviewed for this paper. Seen in this light, the fragmentation of power between centre and state governments and between multiple federal agencies is consistent with a competitive clientelist settlement. While formal laws and policies state that there should be accountability for governors and state-level institutions, strong enforcement of accountability around the budgets and personnel they control (including in the health sector) has often been lacking.

This structure of decentralized power with limited accountability is in many ways a legacy of colonial rule (Kohli 2004; Siollun 2021), in which the British failed to invest in national institutions such as a meritocratically recruited civil service, instead relying on various forms of localized, patrimonial and often indirect rule, giving arbitrary and unchecked power to local elites (Mamdani, 1996). This legacy persisted in the clientelist strategies pursued by Nigeria's main political parties during the 4th Republic, which has also been facilitated by oil revenue (Usman, 2020).

Our findings are largely consistent with other recent analyses of these reforms in Nigeria (Alawode *et al.*, 2022; Ezenwaka *et al.*, 2022; Etiaba *et al.*, 2023). Etiaba *et al.* (2023) identify collaborative governance as the most relevant theoretical framework, and identify an overly top-down, insufficiently collaborative approach as a key impediment to SOML and SURE P success. Ezenwaka *et al.* (2022) similarly criticize top-down programme design in the NHIS/MDG/Free MCH programme. Our respondents strongly agreed that consultation with state-level actors was critical: SURE P MCH programme staff, for example, felt it was a major part of their ability to operate a federal programme focused on PHC. However, our analysis suggests that broader institutional reforms to shift incentives and improved accountability (of the kind envisioned by NHA architects) would likely also be required for successful implementation and sustainability.

Our findings can be informed by other research that examines the relationship of political settlements to health system performance, for example in Uganda (Bukenya and Golooba-Mutebi, 2020) and in Ghana (Abdulai, 2018). Both emphasize the potential for local (subnational) coalitions for effective service delivery, which can emerge under competitive clientelist settlements. Abdulai (2018) identifies 'pockets of effectiveness' that emerged due to dynamic subnational health managers in Ghana, while Bukenya and Golooba-Mutebi provide an example of how pro-health coalitions can emerge among district politicians, hospital managers, NGOs and local business leaders.

We conclude with three factors that could contribute to the emergence of such coalitions in Nigeria. First, since states have significant policy autonomy (and since previous reforms have strengthened state health institutions and opened new funding sources), a pro-health coalition at state level would have scope to make significant improvements. Usman (2020) demonstrated that sectoral reform was possible at national level in Nigeria, when economic shocks forced a change in the political settlement. Identifying the analogous conditions for health reform at state level is a promising area for future research. Second, we highlight 'policy learning' over time, which has improved policy design and the political feasibility of reforms: SOML reflected what policymakers had learned from the MSS, from polio campaigns, and from global experience with CCTs. Similarly, by embedding their reforms in legislation and by institutionalizing the steering committee and financing system in government structures, NHA architects learned from SOML. They also saw themselves as learning from Prof. Ransome-Kuti's PHC reforms, which lacked a stable source of recurrent financing, from NSHIP's use of direct facility financing, and from the UBEC education programme, in which education funding was earmarked but rarely disbursed. Finally, we note the increased efforts to use health policy reforms to change governance dynamics. Health reformers have increasingly tried to address these structures of unaccountable state-level power by embedding governance components in their reforms— one senior reform architect noted that 'the health bill [NHA] was trying to get through the back door what we couldn't get through the constitution' (Interview 13). However, institutional reforms which redistribute power are rare without crisis or high-level leadership. In the period discussed in this paper, senior politicians did not engage on institutional reform; there was no overarching *force majeure* to force competing health agencies to coalesce around a single vision. If future political leaders were willing to expend political capital on health reforms, comprehensive institutional reforms could be possible.

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- Conception or design of the work: KC
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- Data analysis and interpretation: KC
- Drafting the article: KC
- Critical revision of the article: KC and OO
- Final approval of the version to be submitted: KC and OO

Authorship

One author is Nigerian and the other author is American. Although the senior author (Osondu Ogbuoji) is currently US-based, he was born and raised in Nigeria, did his first degree and medical training there and retains close personal and professional links with Nigeria.

Reflexivity statement

One author is Nigerian and the other author is American. Both authors are junior faculty at US institutions. The authors

have diverse methodological training (including social science and medical/clinical training). Given that this is qualitative research based on findings from key informant interviews, their differing backgrounds in some ways shaped their approach to the research process, including interpretation of findings. The authors have made conscious efforts to be conscious of potential biases of this nature. To address potential biases, the authors have also shared multiple drafts of the paper with Nigeria-based individuals and stakeholders who took part in the events in question.

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